LillyPlus® Patient Support Program

Olumiant Patient Support Program
ENROLMENT FORM

Telephone: 1-877-219-8908
Fax: 1-844-344-3546
Email form to: Support@LillyPlus.ca

PATIENT INFORMATION

Last Name:

First Name:

Date of Birth: | **Sex:** ☐ M ☐ F ☐ Other

Address:

City: | **Province:**

Postal Code:

Health Card Number:

Best phone number to contact:

Preferred time to contact: ☐ AM ☐ PM ☐ Can leave a message

Email (optional)**:**

Language Preference: ☐ E ☐ F ☐ Other: _____

OFFICE INFORMATION

Physician information can be stamped in this space:

Physician Name:

Clinic Contact (if not physician):

Address:

Phone #:

Fax #: **Email** (optional)**:**

Preferred method of contact: ☐ Phone ☐ Fax ☐ Email

ASSESSMENT DETAILS

Radiographic Evidence: ☐ Yes ☐ No

RA Factor Positive ☐ Yes ☐ No

Anti-CCP Positive ☐ Yes ☐ No

HAQ _____ **Date** __/__/____ (MM DD YYYY)

DAS28 _____ **Date** __/__/____ (MM DD YYYY)

Swollen joint (#) _____ **Date** __/__/____ (MM DD YYYY)

ACR _____ **Date** __/__/____ (MM DD YYYY)

ESR _____ **Date** __/__/____ (MM DD YYYY)

CRP _____ **Date** __/__/____ (MM DD YYYY)

Systemic Therapies:

Select therapies taken by patient and indicate reason for stopping and end date if applicable:
(IR=inadequate response, IN= intolerance, CI=contraindication)

	IR	IN	CI	Start Date	End Date
Methotrexate	☐	☐	☐	__/__/____ (MM DD YYYY)	__/__/____ (MM DD YYYY)
Leflunomide	☐	☐	☐	__/__/____ (MM DD YYYY)	__/__/____ (MM DD YYYY)
Sulfasalazine	☐	☐	☐	__/__/____ (MM DD YYYY)	__/__/____ (MM DD YYYY)
Other DMARDs_____	☐	☐	☐	__/__/____ (MM DD YYYY)	__/__/____ (MM DD YYYY)

Other reimbursement criteria for coverage

PATIENT CONSENT

SEE FULL PATIENT CONSENT AND PRIVACY INFORMATION ON REVERSE – PLEASE ENSURE THAT YOU HAVE READ AND FULLY UNDERSTAND THE INFORMATION
I have read and understand the patient consent and Privacy Information on the reverse of this form. I consent to the collection, use, and disclosure of my personal information as described.

Patient/
Legal Representative Name: | **Relationship to Patient:**

Signature | **Date:** (MM/DD/YYYY)

MEDICAL DIRECTIVE

I approve to start OLUMIANT® at this time

☐ Yes ☐ No, pending test results ☐ No (Other, please specify) _____

Samples Provided: ☐ Yes ☐ No

RX - OLUMIANT® (baricitinib)

Diagnosis: ☐ **Moderate-to-severe Rheumatoid Arthritis**

☐ **New Prescription** ☐ **Renewal**

2 mg; take one tablet, once daily for _____ days **Number of repeats:** _____

PHYSICIAN ACKNOWLEDGEMENT AND PRESCRIPTION

The use of Olumiant® for this patient is based on my clinical decision-making. I have reviewed the Olumiant® product monograph and informed the patient (or their legal representative) about the potential benefits and risks associated with its use.
PLEASE ENSURE YOU HAVE READ AND FULLY UNDERSTAND PHYSICIAN CONSENT ON THE REVERSE OF THIS FORM.
I have read and understand the physician consent text and agree to the collection, use, and disclosure of my information in accordance with these terms.

☐ **If patient signature was not obtained** in Patient Consent section, check here as your representation of receiving verbal consent from the patient.

Signature: | **Date:** (MM/DD/YYYY)

College License #

olumiant® (baricitinib) tablets

PP-BA-CA-0060E

PATIENT CONSENT AND PRIVACY

The words "you" and "your" on this page refer to the patient, or as appropriate, the patient's parent or legal representative enrolling in the LillyPlus® Patient Support Program (the "Program") on the patient's behalf. The word "representative" means employee, agent, or contractor and "Lilly" refers to Eli Lilly Canada Inc.

Your information will be collected, used and stored as described below and in accordance with Lilly's Privacy Statement. A copy of our Privacy Statement is available upon request by contacting: Chief Privacy Officer, Eli Lilly Canada Inc. Exchange Tower, 130 King Street West, Suite 900, P.O Box 73, Toronto, Ontario, M5X 1B1. For further information please call 1-888-545-5972.

PERSONAL INFORMATION: COLLECTION, USE, AND STORAGE

To participate in the Program, you may be asked to provide personal information to representatives of Lilly or their third-party patient support program providers, including:

- contact information
- personal health information
- information related to insurance coverage
- financial information

This information will be collected, used, and disclosed by Lilly or their third-party patient support program providers to provide the Program services and may be shared with:

- Lilly affiliates.
- Representatives of Lilly and their third-party patient support program providers who have agreed to abide by Lilly's privacy policies.
- Your public and private insurers.
- Your healthcare provider(s), who may share your information with your insurers.

All personal information collected as part of the Program will be:

- Maintained in accordance with applicable legislation, regulations, and guidelines and in accordance with Lilly's Privacy Statement.
- Protected by adequate physical, administrative, and technical safeguards against loss or theft, and against unauthorized consultation, communication, copying, use or alteration. These safeguards will apply regardless of the format in which your information is stored.
- Kept in a personally-identifiable format only as long as needed for the purposes described below.

By providing your email address and enrolling in the Program, you consent to the transfer of your personal information via unsecured email between the Program, your Insurer and Healthcare Provider(s) for the purpose of determining your eligibility for the Program, conducting Program-related activities and the delivery of Program services. You acknowledge that email is not a secure method of communication and that you can withdraw your consent at any time.

Your information may be transferred, stored, and/or processed outside of Canada, including the United States, where local laws will apply.

DRUG SAFETY

Lilly has a legal obligation to report adverse drug events to Health Canada and to monitor product complaints. If you experience an adverse event or a product complaint, Lilly and our representatives will use and report your information for these purposes. Lilly may contact you, your prescribing physician, or another health care provider who may reasonably be assumed to have knowledge of the adverse event or product complaint for additional information to fulfill these obligations.

THE PROGRAM

By enrolling in the Program, you authorize representatives of Lilly and their third-party patient support program providers to collect, use and disclose your personal information to provide the following services:

- Provide product and disease state education.
- Provide new information regarding product and disease state.
- Provide adherence and monitoring services.
- Pursue funding to reimburse the cost of your Olumiant® therapy in part or in full, understanding that reimbursement is not guaranteed. Your physician may be contacted for additional information, if needed, to complete your reimbursement request.
- Review your medical files for purposes of providing the Program services.
- Use your information on an anonymized basis to administer and monitor the Program, assess and demonstrate the effectiveness of the Program, carry out health economic and outcomes-based studies and analyses, and other commercial purposes.

Representatives of Lilly or their third-party patient support program providers may contact you for purposes including, but not limited to:

- Provide Program services.
- Request feedback on your experience with the Program.
- Provide you with updated information on Olumiant® and the Program.

By enrolling in the Program and providing your email address and/or phone number for text messaging, you consent to being contacted by the Program via email and/or text message and to the transfer of your personal information via email and/or text message between the Program, your insurer, and your healthcare provider(s) for the purpose of determining your eligibility for the Program and the delivery of Program services. Email and/or text message may be used during the course of your participation in the Program to inform you about your status in the Program and Program services, and to provide notifications and reminders. You acknowledge that emails and text message are not secure methods of communication. Information in emails and text messages have the potential to be accessed and read by a third party.

You do not have to participate in the Program in order to obtain Olumiant®. Lilly reserves the right to revise or discontinue this Program at any time and is under no obligation to provide you with any assistance at this time or in the future.

WITHDRAWING CONSENT

You can revoke this general authorization and withdraw from the Program by calling 1-877-219-8908. If you do so, your withdrawal is not retroactive - any activities relating to your personal information prior to your withdrawal will not be affected. Your personal information will be deleted and/or maintained in accordance with applicable legislation, regulations, guidelines, and Lilly's Privacy Statement. You can also access or correct your personal information held by Lilly and its representatives. Any information retained by Lilly or their third-party patient support program providers will continue to be handled as described above and in accordance with Lilly's Privacy Statement.

PHYSICIAN CONSENT

I consent to be contacted by representatives of Eli Lilly Canada Inc. and its third-party providers about the patient, Olumiant®, and the Program. I consent to the use of my Program prescribing information for purposes of administering and monitoring the Program, to keep Lilly representatives with whom I interact informed of my use of the Program (only on a patient de-identified basis) and to assess and demonstrate the effectiveness of the Program.

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